

STATE OF MICHIGAN
IN THE MICHIGAN SUPREME COURT

PATRICIA MERCHAND,

Plaintiff-Appellee,

Supreme Court No. 154622
COA Docket No. 327272
L/C Case No. 12-1343-NH

v

RICHARD L. CARPENTER,

Defendant-Appellant.

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**PLAINTIFF-APPELLEE'S ANSWER AND BRIEF IN OPPOSITION TO
DEFENDANT-APPELLANT'S APPLICATION FOR LEAVE TO APPEAL**

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COUNTER-STATEMENT OF JURISDICTION

Plaintiff agrees with the Statement of Appellate Jurisdiction in Defendant's Application for Leave to Appeal.

COUNTER STATEMENT IDENTIFYING THE JUDGMENT APPEALED FROM

This Ingham County Circuit Court medical malpractice case was tried to a jury and resulted in a verdict of no cause of action on entered on April 21, 2015. Plaintiff-Appellee (Plaintiff) appealed by right. One of the issues raised by Plaintiff was the trial court's denial of certain other acts evidence that supported Plaintiff's testimony that Defendant did not record her post-operative complaints and her theory that Defendant did not record post-operative complaints in cases where there were complications suggestive of a surgical mistake as a way to shield himself from liability.

The other acts evidence involved claims by other patients that Defendant did not record their post-operative complaints. Plaintiff argued that Defendant employed the same system in her case: Defendant, who did not create a detailed surgical record, caused an injury to Plaintiff's right hypoglossal nerve ("HGN") during surgery to remove her right submandibular gland and did not chart any of Plaintiff's post-operative complaints, which were indicative of nerve injury. The trial court ruled the evidence inadmissible on the basis that it was irrelevant or, if relevant, the probative value was substantially outweighed by undue prejudice to Defendant, under MRE 403.

The Court of Appeals Majority (Owens, P.J., and Borrello, J. (hereinafter "Majority")) held the trial court had abused its discretion when it prohibited Plaintiff's expert Dr. Morris from offering testimony regarding the parallels between Defendant's system of record keeping in Plaintiff's case and his system of record keeping in other cases in which he committed errors in surgery, resulting in significant injuries and post-operative complaints by the patients. The Majority found the proffered testimony properly evidenced a plan, scheme or motive to avoid liability by failing to record the post-operative complaints of the surgical patients on whom he performed negligent surgery, and was admissible under MRE 404(b).

The Majority noted, if a jury were presented with the excluded MRE 404(b) evidence, it could reasonably have found support for Plaintiff's assertion that Defendant injured Plaintiff's nerve during the surgery, which was the central issue at trial. The Majority found that the probative value of the evidence is not substantially outweighed by unfair prejudice, and that "[f]airness and accuracy demands that the jury be presented with sufficient evidence to determine" whether, in light of Plaintiff's trial theory, Defendant's post-operative notes which did not include any of the problems Plaintiff testified she told him about, was due to his systematic omission of complications traceable to Plaintiff's surgery in order to insulate himself from liability or simple charting errors, as suggested by Defendant.

The dissent (O'Brien, J.) found that the other acts evidence presented was irrelevant because Plaintiff did not allege that improper record keeping caused her injury and did not agree that the evidence showed a system, plan, or scheme to shield Defendant from liability. The dissent also found that the evidence was properly kept out for the reason that any probative value was substantially outweighed by undue prejudice to Defendant. (Dissenting opinion).

The second issue raised in Defendant's Application for Leave to Appeal involves the *res ipsa loquitur* jury instruction. On cross-appeal, Defendant argued that the trial court erred when it instructed on the doctrine of *res ipsa loquitur* and refused to instruct on medical uncertainties. The Majority upheld the trial court's jury instruction on *res ipsa loquitur*, having presented the required expert evidence that the injury complained of does not happen in the absence of negligence. The dissent disagreed because Defendant's experts testified nerve injury is a known complication of surgery. Plaintiff's expert testified it was a known complication of negligently performed surgery.

The Majority denied Defendant's motion for reconsideration on September 14, 2016. The dissent indicated she would grant reconsideration.

Plaintiff requests this Court deny Defendant leave to appeal the Majority's decision because he has not demonstrated a need to address the application of MRE 403 or the appropriate application of the abuse of discretion standard for MRE 403 decisions. Defendant has not demonstrated that this Court's review is necessary to address the impropriety of propensity evidence, because the evidence at issue was offered for a proper purpose.

COUNTER-STATEMENT OF QUESTIONS PRESENTED

- I. DID THE COURT OF APPEALS MAJORITY CORRECTLY HOLD THAT THE TRIAL COURT ABUSED ITS DISCRETION WHEN IT PRECLUDED RELEVANT OTHER ACTS EVIDENCE WHICH SUPPORTED PLAINTIFF'S ARGUMENT THAT DEFENDANT FAILED TO RECORD HER POST-OPERATIVE COMPLAINTS TO SHIELD HIMSELF FROM LIABILITY FOR NEGLIGENTLY INJURING PLAINTIFF'S RIGHT HYPOGLOSSAL NERVE DURING BENIGN SUBMANDIBULAR GLAND EXCISION SURGERY?**

Plaintiff/Cross-Appellee says, "Yes."

Defendant/Cross-Appellant says, "No."

The trial court says, "No."

The Court of Appeals says, "Yes."

- II. DID THE COURT OF APPEALS MAJORITY CORRECTLY HOLD THAT THE TRIAL COURT DID NOT ERR IN GIVING THE STANDARD JURY INSTRUCTION, M CIV JI 30.05 [RES IPSA LOQUITUR] AND NOT THE JURY INSTRUCTION ON MEDICAL UNCERTAINTIES [M CIV JI 30.04] WHERE PLAINTIFF PRESENTED EVIDENCE TO SUPPORT THE DOCTRINE OF RES IPSA LOQUITUR?**

Plaintiff/Cross-Appellee says, "Yes."

Defendant/Cross-Appellant says, "No."

The trial court says, "Yes."

The Court of Appeals says, "Yes."

COUNTER-STATEMENT REGARDING GROUNDS
FOR SUPREME COURT REVIEW

Supreme Court review is unnecessary where the issues on appeal involving the admission of other acts evidence and the *res ipsa loquitur* jury instruction involved an application of the rules of evidence and well settled Michigan law, and the Majority correctly applied both the relevant law and appropriate evidence rules in making its decision.

The Majority correctly applied MRE 404(b), the rule regarding other acts evidence, and recognized the other acts evidence was offered by Plaintiff for a *proper purpose*. “The question is not whether the evidence falls within an exception to a supposed rule of exclusion, but rather whether the “evidence [is] in any way relevant to a fact in issue” other than by showing mere propensity. . . . ‘Put simply, the rule is inclusionary rather than exclusionary.’” *People v VanderVliet (Amended Opinion)*, 444 Mich 52, 65; 508 NW2d 114 (1993), amended 445 Mich 1205; 520 NW2d 338 (1994), citing *People v Engelman*, 434 Mich 204, 210; 453 NW2d 656 (1990).

Under MRE 404(b), other acts evidence that is *only* offered as propensity evidence is improper. If relevant evidence is offered for a proper purpose, it is generally admissible. Only marginally probative evidence that is substantially prejudicial, will be kept out. Defendant thoroughly briefed and argued that the other acts evidence was too prejudicial to him to be admitted. The Majority disagreed with him and its ruling was in accordance with prior holdings in Michigan regarding other acts evidence.

Defendant cites the case of *Wlosinski v Cohn*, 269 Mich App 303; 713 NW2d 16 (2005), a wrongful death medical malpractice case, as support for his claim that the Majority improperly found the other acts evidence admissible, but the evidence at issue in that case was not offered for a proper purpose. *Wlosinski* involved the doctrine of informed consent. The plaintiff’s expert

testified about the surgeon's statistical success rate, but the bare statistics, totally unrelated to the risks of transplant surgery and unrelated to the issue of informed consent, were not valid evidence of negligence. Under the circumstances of that case, the evidence served no proper purpose and so was inadmissible as prohibited character evidence. *Id.*, at 311.

Unlike the evidence at issue in *Wlosinski*, the other acts evidence proffered by Plaintiff was in support of Plaintiff's testimony that she repeatedly told Defendant about her post-operative complications and he never recorded any of her complaints, instead reassuring her that it was all "part of the healing process." Plaintiff maintained that Defendant did this in her case in order to insulate himself from potential liability. The other acts evidence likewise involved claims that Defendant failed to record the problems patients experienced post-operatively, which were in fact likely related to his surgery. The Majority correctly recognized this and properly held that the trial court abused its discretion by ruling the evidence inadmissible.

Defendant complains that, unlike the dissenting opinion, the Majority's written opinion did not specifically outline his claims of prejudice, and that this means the Court of Appeals must not have considered his arguments regarding prejudice or did not properly conduct a balancing test under MRE 403. The Majority did not agree with Defendant's arguments; this doesn't mean the Majority did not consider them. Defendant's claims of prejudice from admission of the other acts evidence is part of the Court record and was briefed extensively by Defendant. The Majority was apprised of the issues and properly considered the admissibility of the evidence.

Defendant also seeks this Court's review of the Majority's rejection of Defendant's argument that the error committed by the trial court was harmless because he says the failure to document Plaintiff's complaints is immaterial to the case. In support he wrongly claims that it was undisputed that an HGN injury is indicated only if the gross abnormal changes in the tongue

are present within 3-4 months of the surgery. While this could be inferred from Defendant's experts, Plaintiff's experts testified that nerve damage is progressive and the gross abnormal changes Plaintiff had 21 months after the surgery were the result of damage done to Plaintiff's right HGN during Defendant's surgery. This was an issue very much in dispute at trial and Defendant's failure to record Plaintiff's complications after trial were material to the case. The Majority understood the issues raised by the parties and correctly applied the law.

Defendant argues that review is necessary because the other acts evidence the Majority found to be relevant and admissible is irrelevant because this is a case of negligent surgery and there was no claim that Defendant's record keeping caused the damage to Plaintiff's right HGN. Certainly, the damage done to Plaintiff's right HGN was as a result of Defendant's negligent surgery. His recordkeeping did not cause her HGN to be damaged, but that does not mean that his recordkeeping was irrelevant to facts in the case, which needed to be properly analyzed by the jury. The Majority recognized this and correctly held the trial court abused its discretion by the omission of the other acts evidence which supported Plaintiff's testimony and created a proper inference that Defendant failed to record her symptoms after surgery as a way to insulate himself from liability for negligently performed surgery.

Defendant also asserts review by this Court is necessary because the Majority disagreed with his argument on cross appeal that the trial court abused its discretion when it instructed on the doctrine of *res ipsa loquitur*. The Majority found that the trial court's decision was supported by the facts of the case and published authority. It pointed to the specific facts in the case which met each of the four elements necessary to warrant the instruction. Review by this Court is unnecessary.

The relevant law and court rules applicable to the issues in this case have been well settled in Michigan. The Majority correctly applied the law in accordance with established precedent and correctly applied the relevant court rules to the issues before it. It is unnecessary for the Supreme Court to grant leave to Defendant to review the Majority's decision.

COUNTER STATEMENT OF FACTS

A. Background

Plaintiff-Appellant Patricia Merchand brought suit against Defendant-Appellee Richard Carpenter for personal injuries associated with a common surgery Defendant performed on August 3, 2010, to remove Plaintiff's right submandibular gland¹. At the time of the surgery, Defendant was a board certified otolaryngologist. Otolaryngology is the practice of medicine involving ears, nose, and throat. Plaintiff claimed her right hypoglossal nerve² (HGN) which innervates the right side of her tongue, was permanently injured during the right submandibular gland excision surgery. Plaintiff was 60 years old at the time of trial.

Plaintiff's right HGN is permanently damaged. The only dispute at trial was the cause of the injury. Plaintiff's injury causes her to experience pain when she talks, tongue disfigurement, fasciculations of the right half of her tongue constantly rubbing against the roof of her mouth, tongue biting, difficulty talking, eating, spitting, swallowing, speaking and saliva pooling. (3/19/15, 196-198, 200-201, 213, 3/26/15, 23-28) Prior to the August 3, 2010 surgery she did not have any of these problems. (3/19/15, 213)

B. Plaintiff Begins Having Salivary Gland Problems

Plaintiff first began having problems with her salivary gland in 2010. Her primary doctor, Kay McLaughlin, D.O. noted that Plaintiff had sudden onset of swelling in her right salivary gland, and difficulty swallowing. 3/19/15, 209-210, 2/16/15, 8-9, 33. On June 14, 2010, Dr.

¹ The submandibular gland is a salivary gland located under the jaw area.

² The HGN is the 12th cranial nerve. There is a right and a left HGN, providing motor activity to the both sides of the tongue so that the tongue can move. 3/20/15, 19-20.

McLaughlin referred her to Mid-Michigan Ear, Nose, and Throat (MMENT) for whom Defendant worked. (2/26/15, 9-10, 33-34)

Plaintiff first saw Defendant on June 28, 2010 and he gave her Keflex and sent her for a CAT scan. (3/19/15, 209-211) Plaintiff's gland was enlarged but average for someone with this condition. (3/17/15, 110)³ Both the CAT scan and Defendant's own examination revealed Plaintiff's tongue was normal. (3/19/15, 84-85) On Plaintiff's second visit with Defendant on July 12, 2010, he told her if she did not have surgery to remove her right salivary gland her face could begin to droop and it would be irreversible. (3/19/15, 212-213) He said it would take six weeks to recover from the surgery. (3/19/15, 218)

C. Benign Submandibular Gland Excision Surgery and the Hypoglossal Nerve

The submandibular gland sits in an area of the neck called the submandibular triangle, a triangular region surrounded by muscles that form the triangle. (3/23/15, 42, 58) The HGN runs beneath the mylohyoid muscle, which is underneath the submandibular gland itself. (3/17/15, 112) The surgery to remove the gland involves separating the gland which may be diseased or inflamed from the surrounding structures. (3/23/15, 42) Injury to the HGN is a very uncommon injury during the gland excision surgery, because of its location. (3/17/15, 151; 3/23/15, 71)⁴ The surgeon first makes an incision below the jawbone through the skin, subcutaneous tissue, and then through the muscle to the connective tissue, where he can visualize the lower portion of the submandibular gland.

³ Plaintiff had a condition known as sialadenitis, which is a chronic inflammation of the salivary gland. 3/17/15, 127, 131; 3/19/15, 53-54.

⁴ In Dr. Morris's expert opinion, injury to the HGN during this type of surgery is a complication that does not occur in the face of reasonable care and treatment.

Next, the surgeon dissects the tissue overlying the gland to make it visible and may encounter different blood vessels that pass through or into the gland, which have to be identified and tied off or cauterized in order to remove the gland. As the gland is elevated, the muscle underneath the gland can be seen. In that muscle, the lingual and hypoglossal nerves go up to the tongue and pass through the submandibular triangle. The HGN is at the bottom of the triangle. The surgeon has to know where the nerves are when removing the gland, because the gland is in close contact with the nerves, and the surgeon needs to preserve and maintain their integrity. (3/23/15, 42-44, 70)

D. Plaintiff's Right Submandibular Gland Excision Surgery

Having no independent recollection of Plaintiff or her surgery, Defendant solely relied upon his operative note⁵ and treatment records, which were not always accurate and could include errors, as a basis for his testimony. Defendant claimed he told Plaintiff about the surgical risk to her HGN because he "often" told his patients this risk. (3/17/15, 112, 151-153) On August 3, 2010, Defendant performed his 23 minute⁶ surgery on Plaintiff. (3/17/15, 106-107) There was nothing unusual about Plaintiff's anatomy or about the gland other than chronic inflammation. (3/17/15, 112, 114-115, 199; 3/19/15, 101) The two main instruments he used were the harmonic scalpel - a cutting device, and Babcock forceps - a grasping tool. (3/17/15, 186-189, 190-191; 3/23/15, 53) Defendant used the harmonic scalpel for the removal of the gland and to

⁵ The operative note is a statement describing the operation for continuity of care so if someone later on needs to know what the patient had done, they can see from the operative note what the procedure was, the basic instruments used, if there were complications, unusual anatomy, or anything unusual that the surgeon encountered during the procedure. 3/17/15, 199-200.

⁶ This surgery takes Defendant 20 minutes to 1½ hours to perform depending on the specific procedure and things encountered during the procedure; during Plaintiff's surgery he encountered no problems and the surgery went quickly. 3/19/15, 49-50.

dissect the connective tissue away from the gland. (3/23/15, 57; 3/24/15, 26)⁷ The vibration of the harmonic scalpel is used to disrupt tissue through ultrasound energy which also heats the tissue when the surgeon touches the harmonic scalpel to the tissue.⁸ Unlike a scalpel where the surgeon applies finger pressure to cut through tissue, the harmonic scalpel has a technology to cut through tissue where “you don’t really feel that cutting at all.” (3/23/15, 54; 3/24/15, 36) A harmonic scalpel should not be used as a probe. (3/24/15, 35, 107-108)⁹

The harmonic scalpel is used underneath the gland and it is possible to injure surrounding structures if it is not positioned and angled correctly. (3/23/15, 53-57)¹⁰ Positioning and angling the harmonic scalpel when doing tissue dissection is critical because surrounding structures can be injured if the angle of the instrument causes energy to flow in a different direction from what is being cut. The harmonic scalpel can be difficult to manage and the surgeon must pay attention to both the position and the angle of the instrument if vital structures are nearby. (3/23/15, 53-57)

Because the HGN runs beneath the mylohyoid muscle,¹¹ if a surgeon enters or goes deep into the muscle, there is a risk of damage to the nervous structure. (3/17/15, 192) Despite this, it

⁷ The harmonic scalpel had not been developed when Defendant trained over 30 years earlier, but he likes using the harmonic scalpel to dissect tissue when he does this surgery. He described it as “kind of like a little clamp or hemostat” and said “there’s really no heat generated outside of it. It’s all just between the fibers” so it divides and seals off the tissue. 3/17/15, 186-189

⁸ Dr. Harry Borovik testified that if a harmonic scalpel is used properly there is no “thermal spread” outside of the tissues actually touched, a heat cautery of the tissue occurs between the edges of the harmonic scalpel. 3/24/15, 31-32, 108-109.

⁹ Defendant said the harmonic scalpel is a “very nice way” to dissect things. 3/17/15, 187. However, his expert Dr. Borovik does not generally use a harmonic scalpel when performing this surgery and said you do *not* use it for dissection. 3/24/15, 107-108.

¹⁰ Dr. Borovik agreed the harmonic scalpel could injure the HGN if not properly used. 3/24/15, 56-57.

¹¹ The mylohyoid muscle is between the gland and the HGN. 3/17/15, 193-194.

was not Defendant's practice to locate the HGN during submandibular gland excision surgery, but he would identify if it "happened" to be in the area adjacent to the gland. (3/17/15, 111-112) Defendant did not attempt to visualize or locate the HGN during Plaintiff's surgery because (even though he did not remember Plaintiff's surgery) he believed the HGN was not in the surgical field, and his surgical instruments could not have come into close contact with it. (3/17/15, 112, 164, 197) Defendant agreed if he had been in the area where the HGN is located, he could have injured it by the procedure he performed and that a surgeon who is negligent can injure the HGN during benign submandibular gland excision surgery. (3/17/15, 112)

Defendant removed the gland and a stone and gave them to the scrub tech who gave it to a nurse to take to pathology. (3/19/15, 52-53) According to the pathology report, there was no infection in the gland; it was only chronically inflamed. (3/19/15, 53-54; 3/23/15, 51) Although his surgical report did not indicate any portion of the removed gland had been left behind, Defendant testified that he did leave some of the gland behind. (3/17/15, 113-114) No surgical complications were noted. (3/17/15, 115) Defendant testified he used the exact procedure he was trained to use and did use for over 30 years of his career, although until later in his career he did not use the harmonic scalpel, which is a modern, contemporary tool. (3/17/15, 196; 3/24/15, 26)

E. Plaintiff's Difficulties with Her Tongue after Surgery

Prior to her surgery Plaintiff's tongue and HGN were normal. (3/17/15, 105) She had no problems with her tongue or issues with her speech, tongue biting, or saliva production. (3/19/15, 213; 3/19/15, 138, 185) Plaintiff was discharged the same day as her surgery and when the anesthetic wore off her tongue felt "really odd. It felt thick. It just – it didn't feel right, kind of hurt. I was biting it all the time. I was spitting, and it just didn't feel right, like a big thick piece

of dry cardboard in my mouth.” Also, she “had a lot of spit coming out the right side.” (3/19/15, 215-216)

Over the course of the week after surgery Plaintiff continued to experience problems with tongue biting, eating, spitting and chewing. Numerous witnesses testified to personally witnessing Plaintiff’s problems biting her tongue, drooling, spitting, chewing and difficulties with speech within days of the surgery, and testified that these problems have been ongoing since the surgery. (3/19/15, 137-138, 147-149, 184-185; 3/20/15, 130-131)¹² Plaintiff’s mouth was observed to be drawn down and Plaintiff would bite her tongue when talking, exclaiming “ouch!” when she did. Plaintiff said this happened a lot since the surgery. (3/19/15, 118, 120-123, 125, 128, 142) Another witnesses immediately noticed Plaintiff’s voice was different. She slurred her words, was hard to understand and would exclaim “ouch” every couple of seconds when she talked. Weeks after the surgery Plaintiff was observed to clench her teeth when she talked and she drooled a lot. (3/19/15, 142-145, 147, 149) Plaintiff talked like she had a “swollen tongue.” (3/19/15, 184-185) Plaintiff told her doctor (Defendant) about these issues. (3/19/15, 157, 158-159) Witness Andrea Thurston also noticed Plaintiff’s activities were more limited since the surgery and she observed her to be depressed, reluctant to go out and do things as she did before and was embarrassed to talk or eat in front of anybody. (3/19/15, 160, 161-162, 177, 181-183, 194-95, 202-203, 208-209)

F. Plaintiff’s Post-Operative Visits with Defendant

Plaintiff’s first post-operative visit with Defendant was on August 11, 2010, when she had her stitches removed. (3/17/15, 116, 119) The medical record of this visit does not reflect

¹² Swallowing, speech, and chewing, are all functions affected and limited by damage to the HGN. 3/20/15, 38.

that there was any ongoing inflammation or any infection. (3/19/15, 85-86) Plaintiff told Defendant her tongue looked and felt swollen and that she was spitting and biting her tongue a lot, but he reassured her saying what she was experiencing was all normal after surgery and part of the healing process. (3/17/15, 116; 3/19/15, 116-218) Defendant discussion with Plaintiff, but admits Plaintiff may have told him about the problems she was experiencing, and he just did not record it. (3/17/15, 119-120, 123, 132) Defendant testified he is not “specifically aware” of other patients complaining that he failed to chart their post-operative complaints. 3/17/15, 137-138. He said his records were not always accurate and he was sure he has mischarted information in patient charts (3/17/15, 151; 3/19/15, 54-55)

Later that day, Plaintiff called the doctor’s office when she felt ill during lunch and her throat swelled up on one side and fluid was draining from the incision. Plaintiff’s Keflex prescription was refilled and a medical assistant told her the doctor said it was normal and if there were no fever, she did not need to come in. Her next appointment was five days later on August 16, 2010.¹³ (3/17/15, 124-125; 3/19/15, 218-220; 3/20/15, 131-132; 3/26/15, 6-8) Defendant said through the medical assistant to use ice on her swollen neck, and along with the medicines she was given, it could take one to two weeks for the swelling to go down.¹⁴ (3/19/15, 56-58) Three days later the incision began to open up and fluid continued to drain. (3/20/15, 131-132) Plaintiff called Defendant’s office again and Dr. Richardson returned the call. Plaintiff did not have a fever but described the swelling, opening of the incision and the drainage and Dr.

¹³ Defendant knows that there was a problem on August 11, 2010, and Plaintiff was not seen for five days, though it was the practice that if a patient has a problem they are able to get in right away to be seen. Plaintiff called on two other occasions and got the answering service, but there is no record of these calls and Defendant did not remember if she had called twice before she finally saw him on August 16, 2010. 3/19/15, 77-81.

¹⁴ Defendant acknowledged that his records never reflected any ongoing infection. *Id.*

Richardson told her to be on the doorstep first thing Monday morning (August 16, 2010).
(3/19/15, 223-225)

When Plaintiff saw Defendant on the morning of August 16, 2010, she again told him her tongue felt thick and numb, that it was painful and it felt swollen and irritated from biting. She also told him she was spitting, not able to eat and could not swallow because of the pain she felt.¹⁵ (3/19/15, 220-222, 3/20/15, 133-134) Defendant noted in the chart there was “*some swelling and drainage*” and he drained the fluid from the wound, cauterized it and continued Plaintiff on Keflex. (3/17/15, 124-125; 3/19/15, 58-59) Defendant told her the wound looked good, there was no infection and she just needed to just wait and give it time to heal (3/20/15, 132, 3/26/15, 17). The medical records do not reference any infection, and Defendant testified Plaintiff did not have a post-operative wound infection, only routine wound healing. (3/17/15, 125-126) Defendant continually reassured Plaintiff that what she was experiencing was just part of the normal healing process, and he recorded that the wound was “*healing nicely.*” (3/17/15, 126-127; 3/20/15, 131-136) He never recorded any ongoing infection, just that fluid was being drained. (3/19/15, 88-90)

Plaintiff returned to see Defendant two days later on the August 18, 2010 and the wound was still seeping clear fluid. Defendant recorded that the wound was “*healing nicely*” and he again cauterized the portion of the wound and continued her on Keflex to help the wound close and heal. Defendant testified this was normal. Plaintiff never developed a post-operative infection. (3/17/15, 126-127; 3/19/15, 51, 60-61) He did not record Plaintiff’s complaints regarding her continued tongue biting and the difficulties she was experiencing.

¹⁵ This was the only day that Defendant’s medical assistants did anything other than simply show her into the examination room. 3/19/15, 222-223.

On her August 23, 2010 appointment, Defendant recorded that “*the wound appears to be healing nicely. There’s no evidence of infection.*” Defendant also recorded “*there was a small amount of fluid which was removed, a seroma*” which he drained. At this visit he prescribed Septra to help the incision close. (3/17/15, 127-128; 3/19/15, 62-63)¹⁶ He did not record Plaintiff’s complaints of continued tongue biting and other related issues.

On August 30, 2010, Defendant recorded the incision was *healing nicely*. There was *no further drainage, no tenderness, and no abnormalities of salivary gland are noted*. The medical assistant had noted that Plaintiff could feel a hard lump, but this is not noted in Defendant’s record because Defendant felt it was just part of the normal healing process. (3/19/15, 65-66) The record does not mention any infection, nor does it record that Defendant ever believed there was an infection that was taking longer to resolve than he anticipated, which he claimed was the case at trial. (3/17/15, 128-129; 3/19/15, 51-52, 56-58, 63-66)

On September 13, 2010, Plaintiff came in again told him about what she was experiencing, but Defendant recorded only that she was doing well, there was no infection and there were no issues. Defendant testified she was experiencing dry-mouth, which is common for patients to experience, and he recommended a vaporizer in her bedroom, increased hydration, and gave her a prescription. (3/17/15, 129; 3/19/15, 66-67)

On October 13, 2010, Defendant records again that she was “*doing quite well. She’s having no issues at this time*” and she was to return in four months. Defendant specifically testified, “*there was no specific post-operative infection that occurred as a result of the surgery or not,*” and there was no need post-surgically to order a culture and sensitivity to figure out if

¹⁶ Defendant testified that he “didn’t need to” record anything about post-operative infection or ongoing infection, suggesting that all healing surgical wounds are infected. 3/19/15, 91.

there was any infectious process. (3/17/15, 129-132)¹⁷ Defendant agreed Plaintiff was definitely coming back for post-operative checks more frequently than is usual, but he never recorded her complaints or why she was returning more frequently than would be normal. (3/19/15, 67) At trial, Defendant attributed her frequent returns to issues with the ongoing infection he never recorded or cultured, and was not suggested by the pathology report. He surmised there was an ongoing infection because according to his records he prescribed an antibiotic (3/19/15, 58, 68)¹⁸

Even though a January 10, 2011 medical record from Plaintiff's primary care doctor and a separate January 12, 2011 hospital record recorded Plaintiff's tongue biting complaint (3/20/15, 136-137), Defendant did not record this at any prior appointment or when he saw Plaintiff less than two months later. On March 7, 2011 (Plaintiff's last appointment with Defendant) Defendant again recorded in his medical chart that Plaintiff was doing very well and had no issues and was to return to see him in six months. He did not record any of the difficulties she was having. Defendant testified it was his habit and custom to tell patients to call back if they had any issues before their next appointment and maintained at trial that if Plaintiff had called with any issues, it would have been recorded. (3/17/15, 120, 123-124, 132; 3/19/15, 68-71, 74) Defendant never recorded any problems Plaintiff was experiencing, which Defendant testified she "may" have told him.¹⁹

¹⁷ Defendant testified sialadenitis is an "infection" and said pathology reported the gland was chronically infected (3/19/15, 53-54), *this was untrue*. According to the pathology report, the gland was not infected but inflamed. 3/23/15, 51.

¹⁸ Defendant testified at his deposition that there was no evidence of any infection, and that if he had seen evidence of infection, he would have taken a sample and sent it in for culture and sensitivity. 3/19/15, 92-95.

¹⁹ Defendant felt it was "unlikely" that Plaintiff told him of her complaints because he did not record any. 3/17/15, 120, 123-124, 132; 3/19/15, 68-71, 74 Defendant was not "specifically aware" that other patients complained that he failed to chart their post operative complaints and could not "recall any" who did. 3/15/17, 137-138.

Plaintiff's problems with tongue biting persisted between visits to Defendant and her saliva problems actually worsened. At every single appointment up through her final post-operative appointment in March, 2011, Plaintiff told Defendant about the problems she was experiencing, just as she had told others. Yet, Defendant only told her that this was all normal and would take one to two years to fully resolve. (3/20/15, 134, 135-137, 142)

G. Plaintiff's Problems Persist and Worsen

In May 2011, about two months after she last saw Defendant, Plaintiff had her annual examination with her primary care doctor, Dr. McLaughlin. She could not recall if she had repeated her concerns at that time because she had already told Dr. McLaughlin about the tongue biting two months earlier and Defendant had led her to believe what she was experiencing would eventually get better. (3/20/15, 138) She did not notice any fasciculation or deviation or other gross abnormal change of her tongue at that time. (3/24/15, 232, 234)

Over the next 11 months Plaintiff's condition continued to progress. Plaintiff changed her diet to accommodate her problems eating, for example, grinding up nuts to put in her oatmeal, for nutrition, and she avoided going out to eat. (3/20/15, 139-140) She began to experience times when she would aspirate saliva. In April, 2012, Plaintiff noticed her tongue deviating and that there were deep impressions in it and she contacted Dr. McLaughlin because by this time she understandably had lost all faith in Defendant. (3/20/15, 141-142, 3/24/15, 234, 3/26/15, 16; 2/26/15, 16) Plaintiff's appointment with Dr. McLaughlin was on May 10, 2012. Plaintiff went over her symptoms again with Dr. McLaughlin, including how her tongue was starting to curl, and all that had transpired since August 11, 2010. (3/26/15, 8-10; 2/26/15, 13-14) Dr. McLaughlin saw the fasciculations on the right side of Plaintiff's tongue and observed her affected speech, increased saliva, and drooling. (2/26/15, 14, 35)

H. The Cause of Plaintiff's Problems Finally Revealed

Dr. McLaughlin ordered an MRI, which, along with her examination and review of other records confirmed there was denervation of the right side of Plaintiff's tongue. (2/24/15, 212; 2/26/15, 15-17, 19) The right HGN was damaged. According to neurology experts, when this nerve is damaged problems associated with it are progressive, beginning with incoordination of movements of the tongue, affecting biting and chewing as well as causing some difficulty with speech, and eventually leading to tongue atrophy and deviation. (3/20/15, 22, 27-30, 36; 3/4/15, 7-8, 10) Plaintiff finally understood why she was experiencing the various problems she had since the time of the August 3, 2010 surgery. Dr. McLaughlin referred her to see Dr. Radgens, another ENT doctor. (3/20/15, 143-144; 2/26/15, 15, 34)

1. Dr. Radgens concludes Plaintiff's HGN injury had been ongoing since Defendant's surgery

Shannon Radgens, D.O., a board certified in otolaryngologist was qualified as an expert in otolaryngology. (2/27/15, 5) Dr. Radgens examined Plaintiff on June 5, 2012, and read her MRI. *Id.* He noted Plaintiff had denervation of the right side of her tongue, that her difficulties had been ongoing for two years, and that the course of her illness was constant and severe. Plaintiff informed Dr. Radgens she was having difficulty swallowing, was biting her tongue, and her tongue was pulsating and swelling. (2/27/15, 6-7) Dr. Radgens' assessment was tongue weakness and fasciculations to the right side of the tongue following the gland excision surgery

two years earlier. (2/27/15, 16)²⁰ Although he felt it was really too late for microsurgery to help her, he referred Plaintiff to see Dr. Stanley, an otolaryngologist. (3/24/15, 214; 3/9/15, 4-6)

2. Dr. Stanley concludes that the HGN injury was the result of Defendant's surgery or to post-operative complications

Jeffrey J. Stanley, M.D., a board certified otolaryngologist was qualified as an expert in otolaryngology. Dr. Stanley saw Plaintiff on July 26, 2012. He confirmed denervation of Plaintiff's tongue.²¹ Without the benefit of reviewing Defendant's operative note or any of the post-operative records, Dr. Stanley felt the HGN injury was either due to the surgery or to complications after surgery related to a post-operative infection. (3/21/15, 94-95, 3/9/15, 13-14, 25, 27) Dr. Stanley referred Plaintiff to neurologist Dr. Almeida, M.D., for treatment.

3. Dr. Almeida concludes Plaintiff's HGN injury was a result of Defendant's surgery

Andrea A. Almeida, M.D., a board certified neurologist, was qualified as an expert in neurology. Dr. Almeida treated Plaintiff in early April 2013. (3/4/15, 5-7) Upon examination, Dr. Almeida noted the deviation and fasciculations to the right side of the tongue. The tongue was "curled up" which showed her it had been a chronic problem that had been going on for a few years, that had progressed to include tongue atrophy, weakness and fasciculations.²² Dr.

²⁰ When Plaintiff saw her chart after her visit to Dr. Radgens' office, she felt his medical assistant had inaccurately recorded some things in her chart, so she sent Dr. Radgens a note to clarify that her tongue biting happened when she talked and ate and should not be characterized as "constantly" occurring. She also pointed out the MRI was done because of the tongue wrinkling and right side fasciculations. 2/27/15, 17-18; 3/20/15, 144-146.

²¹ Plaintiff gave a history of intermittent tongue biting since the August 3, 2010 surgery, speech and swallow problems, and tongue fasciculations since April, 2012. Her MRI also confirmed denervation of the right side of her tongue. 3/9/15, 5-8, 15-16, 28-29.

²² Dr. Almeida took a history from Plaintiff and noted Plaintiff's problems (tongue heaviness, tongue biting on the right side, saliva and spitting, difficulty with speech, numbness, pain, etc.) began after her August 3, 2010 surgery. 3/4/15, 7-8, 10.

Almeida ruled out other issues involving other nerves. By August 1, 2013, Plaintiff's problems had become stable so she did not see Plaintiff after August 2013. (3/4/15, 12, 14-16, 26-27) In Dr. Almeida's opinion Plaintiff suffered a HGN injury during the August 3, 2010 surgery. (3/4/15, 16, 19)

I. Plaintiff's Lawsuit and the Commencement of Trial

Plaintiff filed her lawsuit against Defendant for medical malpractice on December 17, 2012. Defendant acting in the capacity of an expert filed his affidavit of meritorious defense on behalf of himself pursuant to MCL 600.2912e, attesting that he did not violate the standard of care during Plaintiff's surgery. Jury trial commenced on March 16, 2015.²³

J. Defendant Testifies about Proper Surgical Technique Used in Benign Submandibular Gland Excision Surgery

Beginning with Defendant's opening statement, the jury was told Defendant was a very experienced surgeon, had used proper techniques for 28 years, and had performed hundreds of these routine surgeries and took his training, his experience, appropriate tools and technique and performed Plaintiff's surgery within the standard of care. This portrayal of Defendant continued

²³ Prior to jury selection, Defendant asked the trial court to reconsider the two pretrial rulings adverse to Defendant. The court first addressed Defendant's motion *in limine* regarding Defendant's 2013 arrest, charge, plea or conduct in fraudulently obtaining controlled substances. Defendant argued the case was not a "he said/she said" type of case (3/16/15, 15) and the issues surrounding Defendant's conduct in fraudulently obtaining controlled substances would be too prejudicial. (*Id.*) Plaintiff argued this was a "he said/she said" type of case and Defendant's credibility was critical (3/16/15, 23-24), but the trial court prohibited Plaintiff from inquiring into any matter concerning Defendant's credibility which did not "reasonably relate" to Plaintiff because any other matter would be too prejudicial to Defendant. (3/16/15, 30-31) Next, Defendant asked the court to reconsider its pretrial ruling denying their motion *in limine* regarding the circumstances of Defendant's termination from MMENT on the basis that any reasons why Defendant left MMENT's employment would be irrelevant. (3/16/15, 35-36) Plaintiff argued that Defendant was fired because of issues involving credibility (3/16/15, 43), but the trial court reversed its prior ruling and granted Defendant's motion because Defendant sued MMENT over his firing and there was a confidential settlement. (3/16/15, 46-48)

with Defendant's own testimony about his background, training, accolades, board certification, surgical experience and that he had performed hundreds of these routine surgeries. (3/17/15, 50-55, 75-76, 90-91; 168-179) Defendant also gave an anatomy lesson using demonstrative aids, explaining all of the structures in the surgical area and going through a routine benign submandibular gland excision surgery, telling the jury it was the technique that he personally used for 30 years of his career, although he now uses the harmonic scalpel for cutting. (3/17/15, 183-196) Defendant then told the jury that this was just how he performed the surgery on Plaintiff. (3/17/15, 197)

At the start of the third day of trial, Plaintiff's counsel pointed out that Defendant had presented himself to the jury as an expert and he had falsely suggested to the jury that he was still practicing medicine.²⁴ But the trial court did not see him as an expert with all of the issues pending before the court and would not be qualifying him under MRE 702 and MRE 703. Nevertheless, Defendant presented his opinion on the ultimate issue before the jury when his attorney read from his affidavit of meritorious defense:

... it is my opinion that there is no causal relationship between the plaintiff's allegations of negligence or malpractice and defendant's care and treatment of the patient, as the injuries of which plaintiff complains can and do occur in the absence of negligence or malpractice. [3/17/15, 165]

K. Defendant Cannot Explain Plaintiff's Injured HGN, but Maintains it is Not His Fault

Defendant became aware that Plaintiff was diagnosed with a hypoglossal nerve injury at some point, but could offer no explanation for it. (3/17/15, 137, 161) Defendant agreed that

²⁴ The trial court acknowledged that Defendant's testimony did make it sound like he was out there still doing surgery when he really was not, but said it would be ok for Defendant to say he was retired and he did not have to say why he was not practicing medicine now. 3/19/15, 22-23.

surgical injury to the HGN during benign submandibular gland excision surgery is very, very rare. Yet, Defendant maintains he did not encounter the right HGN during his 23 minute surgery as it was not part of the surgical field, so he could not have injured it. (3/17/15, 151, 163, 197) He said if he had injured the HGN with the harmonic scalpel Plaintiff would have had “immediate paralysis of that side of her tongue” which would have been obvious. (3/17/15, 197-198)²⁵ Defendant denied responsibility for the HGN injury, though he did not know of anything that could account for it. (3/17/15, 161-162)

Although Defendant had no explanation regarding the cause of Plaintiff’s HGN injury, in his affidavit of meritorious defense, he opined that HGN injuries “can and do occur in the absence of negligence or malpractice” and this was read to the jury. (3/17/15, 161-162, 165) He did not offer any mechanism of how injury to the HGN can occur in the absence of negligence. The only suggestion made had to do with a *severe* post-operative infection which Defendant himself testified did not occur.

L. Experts Testify That, Within a Reasonable Degree of Medical Certainty, Defendant’s Surgical Technique is the Most Likely Cause of the HGN Injury

1. Dr. Morris

Michael Morris, M.D., a board certified otolaryngologist, was qualified as an expert in the area of otolaryngology. Throughout his 27 years of practice as an ENT doctor he has spent the majority of his practice seeing and evaluating patients. Patients with issues involving the submandibular gland is a regular part of his practice, which includes surgery to remove a submandibular gland. Dr. Morris testified regarding the standard of care and offered his opinions

²⁵ Defendant did not recall ever seeing any other patient who underwent this surgery whose HGN had been injured. 3/19/15, 97.

within a degree of medical certainty regarding Defendant's care and treatment of Plaintiff.
(3/23/15, 23, 26-28, 31, 35)

In submandibular gland excision surgery, the surgeon must know where the lingual and hypoglossal nerves are, so part of the surgical technique is for the surgeon to identify important structures that are in the region of the gland being removed and describe how he goes through the process of removing the gland. (3/23/15, 44-45) Injury to the HGN during benign submandibular gland excision surgery is very rare. It is not an injury that would ordinarily occur absent negligence. (3/23/15, 42-45, 48, 52, 65-69, 71, 87, 125-126, 129, 137, 150-151, 160-161)

After reviewing Defendant's testimony and the records regarding his care and treatment of Plaintiff, Dr. Morris concluded that Defendant breached the standard of care during the 23 minute surgery and caused Plaintiff's HGN injury. HGN injury is very rare during benign submandibular gland excision surgery. There was no mention in Defendant's record of anything to indicate he protected the HGN during surgery and *nothing in the record could account for Plaintiff's HGN injury*. It was more likely than not Defendant used an improper technique during the surgery, and that the injury to Plaintiff's HGN occurred during Defendant's dissection of the submandibular gland with the harmonic scalpel. (3/23/15, 60-61, 69-70, 72, 74, 113-114)

Interpreting Defendant's operative note, Defendant used the harmonic scalpel to remove the gland by pulling it out of the cradle of tissue in the submandibular triangle, and so directed the harmonic scalpel underneath the gland in the area of the hypoglossal nerve as the gland was pulled out. (3/23/15, 59) The harmonic scalpel must be oriented properly when taking down the connective tissues during the surgery and the angle of orientation is a key part of the surgery. (3/23/15, 58-59, 113-114, 117, 121, 129, 146-147) If the surgeon encounters some adhesion or inflammation, or problems on the outside of the gland that cause the gland to stick to surrounding

tissues, the surgery is more difficult and can take one hour or more to perform. (3/23/15, 52)

According to the report, Defendant did not encounter any scar tissue, inflammation, or infection during the surgery. The pathology report confirmed there was no infection in the area where the gland was removed. (3/23/15, 33, 37-38, 49-52)

The injury to Plaintiff's right HGN, which is irreparable (3/20/15, 31), was not the result of a minor stretch injury to the nerve, which might cause a transient paralysis of the HGN, which would come back within four to six weeks. (3/23/15, 90)²⁶ In this case, the injury to Plaintiff's HGN occurred during the Defendant's operation because there was no other event going forward that would account for the injury. It is not possible to injure the HGN by biting down hard on your tongue. (3/23/15, 96-97) In addition, there was no raging infection that would account for the HGN injury. Significantly, Plaintiff described symptoms consistent with a HGN injury after the surgery. (3/23/15, 90-95)

According to Defendant's records, Plaintiff's surgical wound healed nicely and she did not have an infection in the post-operative period.²⁷ Had Plaintiff developed a post-operative infection, any problems Plaintiff may have experienced with the HGN as a result of the infection would have been transient. There were no indications in the records of a *significant* post-operative infection that would have had any influence on the HGN. (3/23/15, 93-95, 157-158)

²⁶ Dr. Stanley also testified that a stretch injury during surgery would only cause the nerve to cease functioning temporarily. 3/9/15, 25-26. Dr. Schechter testified similarly, that Plaintiff's injury was not the result of a stretch injury. 3/20/15, 33.

²⁷ Despite there being no reference to infection in any post-operative record, Dr. Morris believes Plaintiff did have some post-operative infection that was successfully treated with antibiotics by the time she had her August 30, 2010 check-up. 3/23/15, 142. Dr. Stanley's opinion that a post-operative infection could have caused Plaintiff's nerve injury was made without the benefit of reviewing Defendant's surgical note and post-operative records. 3/23/15, 94-95, 3/9/15, 27.

In any event, an infection “absolutely did not” cause the HGN injury because according to Defendant’s notes, Plaintiff did not have an infection and when he post-surgically drained Plaintiff’s wound, because what he drained was not an infection, but a seroma.²⁸ After careful consideration of the ascertainable facts, Dr. Morris’s opinion to a reasonable degree of medical certainty, was that Plaintiff’s right HGN was injured due to the negligent way Defendant used the harmonic scalpel when performing Plaintiff’s surgery. (3/23/15, 61, 72, 88-89, 97-98, 149-150, 152, 154)²⁹

2. Dr. Schechter

Steven Hart Schechter, M.D., is board certified in neurology as well as clinical neurophysiology. He was qualified by the trial court as an expert in neurology. Neurologists deal with the diagnosis and treatment or management of nerve injuries and neurological diseases. They identify the problem, figure out the cause, and then recommend a course of treatment, which might include medical management or possibly surgical intervention. (3/20/15, 14-15, 18)

In the course of his practice, Dr. Schechter has seen patients who have had injuries to the hypoglossal nerve. Trauma is the usual cause of an injury to the hypoglossal nerve. Something has compressed the nerve causing the nerve to lose its ability to function. “The nerve is like a wire, so if there’s a compression to that nerve or a cut into that nerve, the nerve will lose its function.” (3/20/15, 20, 46) In submandibular gland excision surgery, a hypoglossal nerve can be injured by different surgical instruments, such as clamps, retractors, a scalpel, or heat.

²⁸ A seroma is a collection of fluid under the skin, it is not an infection. 3/23/15, 91.

²⁹ The tip of the harmonic scalpel would have been within one millimeter of the HGN only for an instant to cause the type of injury to the nerve that occurred. 3/23/15, 117-118. Defendant’s expert Dr. Borovik agreed that a negligent surgeon can cause injury to the HGN during this type of surgery and that if the harmonic scalpel, which should not be used as a probe, is used inappropriately, it can cause injury. 3/24/15, 35, 109, 112.

Dr. Schechter noted Plaintiff did not have the symptoms prior to the surgery, was symptomatic immediately after the surgery, and importantly there was a progression of symptoms which eventually led to the tongue deviating because of atrophy and Plaintiff continues to remain symptomatic. (3/20/15, 19-20, 27, 70-71) Dr. Schechter's opinion to a degree of medical certainty is that Plaintiff's HGN was injured during surgery by something Defendant did. (3/20/15, 27, 32-33, 74) No other cause than injury due to Defendant's surgical procedure, fits Plaintiff's situation.³⁰ Defendant's surgery was unquestionably the cause of the injury to Plaintiff's HGN. (3/20/15, 35) In Dr. Schechter's expert opinion, the most likely way the nerve was damaged was by a transection, which is a cutting or lesioning through of the nerve in a way that caused it to lose its function. (3/20/15, 39-42)

If one of the HGNs is injured during surgery, the effect on the tongue *cannot be seen immediately*; you do not get immediate, total paralysis of the tongue. There is an evolution of deficits which take time to develop (3/20/15, 36-37, 52):

When a nerve is cut there's a process that takes place. It's not like you have the cut nerve and then immediately you see the atrophy, you see the denervation, you see the deviation and dysfunction. It's a process that involves over time, and that time can be weeks, months, even years, and what happens is the function to that nerve is lost and this process occurs or takes place, this sort of dying back process, and so when we see this type of injury there is an evolution of the deficits that occurs. It's not a light switch and on day one she's got what she's got. It's a process that evolved where she had symptoms and those symptoms progressed to a point where it reached the full evolution, and I believe that's where we are now with ongoing, persistent, permanent deficits. (3/20/15, 36)

³⁰ Infection is unlikely from a medical standpoint in this case due to the time course and severe nature of the trauma to the nerve. Adhesions or scar tissue developing after the surgery itself is implausible when you look at Plaintiff's clinical presentation. It is impossible that Plaintiff caused her injury by biting down hard on her tongue. The injury was also not caused by a minor stretch to the nerve during surgery. 3/20/15, 33-35, 66-67, 81.

The degree of damage to Plaintiff's nerve suggested that the right HGN was transected, compromising the integrity of the nerve to the tongue. (3/20/15, 33-34, 79) Dr. Schechter explained that the injury to Plaintiff's right HGN was absolutely not the result of a post-operative infection:

When you think of a wire, an electrical wire, something completely blocked any impulses from going through. An infection simply wouldn't do that. It wouldn't do it acutely. It wouldn't do it to that degree of severity, and it wouldn't cause a permanent loss of function. [3/20/15, 79]

None of Defendant's records show Plaintiff had a post-operative infection. (3/20/15, 77-79) Dr. Schechter pointed out that even if there had been a post-operative infection it would be very implausible to have involved the nerve, unless it was "a huge major infection" that certainly would have been recorded by Defendant. Also, after treatment of an infection, there would be improvement. Plaintiff's symptoms have not improved. So, to say an infection caused Plaintiff's HGN injury "doesn't fit. It doesn't fit with the time course and it doesn't fit with the level of severity and it doesn't fit with the permanency that [Plaintiff's] experienced since the event occurred." (3/20/15, 34, 79-80)

Dr. Schechter explained when a nerve is transected, the full affect of that transection is not always seen right away; there is an evolution over time. Plaintiff was aware something was wrong immediately following the surgery. Plaintiff's issue with tongue biting was noted in several records in 2011, including in January while she was still treating with Defendant. (3/20/15, 74-75) Over time Plaintiff's symptoms continued to progress and later fasciculations developed, indicating chronic denervation. When there is atrophy to one side of the tongue, the tongue will *eventually* deviate towards the side of the lesion; it does not happen immediately. (3/20/15, 28-29, 51-52, 73-74) Dr. Schechter explained why it takes some time for the denervation process to develop after a HGN injury:

The nerve [following injury] kind of dies back. It's kind of a de-connection or de-afferentation of the nerve and that disconnection over time leads to atrophy because the muscle isn't receiving its nerve input so the muscle dies away, but it doesn't happen immediately. It's a progression, and that's exactly the course that she experienced, was a progression of symptoms. [3/20/15, 29]

In Dr. Schechter's expert opinion there is nothing unusual about the fact that Plaintiff did not develop fasciculations or tongue deviation until April 2012, and was not diagnosed with atrophy of the tongue until her medical appointment in May 2012. The tongue fasciculations can develop over an extended period of time after the original HGN injury. In fact, according to Dr. Schechter, the time course of Plaintiff's symptoms is very typical for what would be seen with an injury to the right HGN. (3/20/15, 28-31, 62)

M. Defendant's Experts Do Not Believe Plaintiff's Injury Occurred at the Time of the Surgery Based on Timing of Plaintiff's Complaints

1. Dr. Borovik

Harry R. Borovik, M.D., is a board certified otolaryngologist and was qualified in that area by the trial court. (3/24/15, 11, 24) Dr. Borovik agreed that a negligent surgeon can cause injury to the HGN during benign submandibular gland excision surgery. (3/24/15, 20-21, 109) However, in his opinion, HGN injury can occur even when the surgeon performed the operation within the standard of care, although he did not testify about what the mechanism of such an injury would be. (3/24/15, 38, 40-42)³¹

Like Dr. Morris and Dr. Rontal, Dr. Borovik does not do benign submandibular gland excision surgery as quickly as Defendant performed the surgery on Plaintiff; Dr. Borovik generally does not use a harmonic scalpel and his surgeries normally take an hour or sometimes

³¹ Although Dr. Borovik testified the standard of care does not involve identification of the nerves in the surgical area that might be at risk, when he personally performs the surgery, he uses a nerve monitor, looks for the HGN and makes a point to always identify the lingual nerve so it is not injured. 3/24/15, 23, 83, 85.

more. (3/24/15, 57, 82) Other noted differences are that Defendant uses a harmonic scalpel for dissection, does not identify the lingual nerve when he performs the surgery and there is no evidence that Defendant ever uses a nerve monitor during surgery. (3/24/15, 83-86, 107-108)

When describing the surgery, Dr. Borovik pointed out that the mylohyoid muscle is retracted and the submandibular gland “dives down deep” so that if the HGN traverses through the deep structures that the gland is attached to, the surgeon must be careful to “stay on the gland” to avoid the HGN. (3/24/15, 26-27) If the surgeon does not hug the gland there is a potential for HGN injury. (3/24/15, 86-87) Dr. Borovik noted he does not use the harmonic scalpel for dissection and it should not be used as a probe. (3/24/15, 35) In addition, in a gland that is chronically infected, it is very difficult to see where the surgical planes are because they are “kind of melded together so the surgery can be complicated.” (3/24/15, 28)

Dr. Borovik could not explain how or why Plaintiff’s right HGN injury occurred. (3/24/15, 87) He has never had a patient experience permanent problems with their tongue after benign submandibular gland surgery. (3/24/15, 107) He noted that, if the harmonic scalpel is used within the standard of care for these procedures, it would not injure the HGN. (3/24/15, 56-57) He agreed Defendant’s surgical note was limited, and the post-operative notes were inadequate and contained discrepancies. (3/24/15, 82, 89, 93-94)³² Nevertheless, Dr. Borovik told the jury his opinion was that Defendant did not damage the HGN during surgery. (3/24/15, 46-50, 69-70)

³² Dr. Borovik even asked for additional information regarding how the surgery was performed when he was reviewing this case because of the limited surgical note, 3/24/15, 82, and Dr. Borovik agrees that nothing in the post-operative notes suggests Plaintiff ever had a post-operative infection. 3/24/15, 64, 68-69, 87-89, 94-95.

The main reason for Dr. Borovik's opinion that the HGN was not injured during the surgery was that there were no visible, significant motor function deficits described by a "medical person" between the time of the surgery on August 3, 2010 and April, 2012. The timing of Plaintiff's reporting her tongue fasciculations to her primary doctor was critical to Dr. Borovik's opinion. (3/24/15, 120, 122)³³ He believes what was visible in April, 2012 (tongue fasciculations and deviation) would have been visible in January 2011. (3/24/15, 116-117)³⁴ Although not a neurologist and his practice does not focus on nerves, in Dr. Borovik's opinion, if there had been an injury to the HGN, the deviation would have happened immediately and been obvious, and the fasciculations would have developed within 3 to 4 months of the HGN injury. (3/24/15, 61-62, 64-65, 67, 70, 74)

2. Dr. Rontal

Eugene Rontal, M.D., a board certified otolaryngologist, was qualified as an expert in that area. He mostly reviews medical malpractice cases for the defense. (3/24/15, 130-131, 146, 177) He testified that the most common complications in submandibular gland excision surgery are infection, bleeding, and nerve injury, specifically the marginal mandibular nerve, the lingual nerve and the HGN. He includes the HGN as a nerve that is at risk anytime you do the surgery because the HGN is in the area where the submandibular gland is located. (3/24/15, 146) He is unaware, though, of any surgeon who has actually injured the HGN during benign submandibular

³³ "It's one thing for a patient to have subjective, meaning complaints of feeling something, that they can relate that they felt back to a point in time. It's another to have a medical expert say, there's definite observable deficiency or dysfunction" and Dr. McLaughlin did not see tongue fasciculations in May 2011. 3/24/15, 116-117, 126-127.

³⁴ Dr. Borovik believes the denervation of Plaintiff's tongue *began* more than one year after the surgery based on his belief that there would have been substantial evidence of motor function deficits at the time of the surgery. 3/24/15, 70, 72, 75.

gland excision surgery. (3/24/15, 197) He said a doctor can perform surgery within the standard of care and injure the HGN because “we’re not robots” and “Medicine is tough” and “you can’t always see everything you do.” (3/24/15, 146-147)

Even though he testified the HGN is always at risk because it is in the area where the gland is located, he does not go looking for it and he does not see it except on occasion after the gland has been removed. (3/24/15, 147, 187) He disagreed with the *Cummings* textbook, which he agreed was an authoritative text in otolaryngology, and testified that just because the authoritative text suggests the submandibular gland excision surgery always exposes the HGN and the lingual nerve, that does not make it so. (3/24/15, 182-184) Like Dr. Borovik, Dr. Rontal does not perform benign submandibular gland excision surgery the same way as Defendant. (3/24/15, 154-155, 196) Also similar to Dr. Morris and Dr. Borovik, Dr. Rontal takes 1½ hours to perform the surgery. (3/24/15, 198)

Dr. Rontal could not say what caused Plaintiff’s permanent injury to her HGN. (3/24/15, 182, 186) Dr. Rontal noted that Defendant left things out of his records, yet he did not find evidence that the HGN was injured during surgery. (3/24/15, 154, 158, 167-168, 191) His opinion, like that of Dr. Borovik, rested largely on the timing of Plaintiff’s symptoms. He felt if Plaintiff’s HGN injury had occurred during the surgery, the tongue would have immediately stopped moving. He characterized it as an “instantaneous cataclysmic” event where the tongue would deviate to the side where the lesion occurred. (3/24/15, 162-163, 167-168) According to Dr. Rontal, tongue deviation and fasciculations would develop within two to three months of an HGN injury, so based on when Plaintiff’s deviation and fasciculations were noted, the injury could not have occurred at the time of surgery. (3/24/15, 164-165)

Both Drs. Borovic and Rontal agreed that tongue biting is consistent with, but “not necessarily” evidence of, HGN injury because there can be many reasons a person is biting their tongue. Dr. Borovic found it to be a common complaint or problem of patients immediately after submandibular gland excision for a period of weeks. (3/24/15, 68, 97-98, 106) And though Dr. Rontal had never seen tongue biting as an indication of HGN injury, he agreed it was possible. (3/24/15, 189, 191, 194)

N. Separate Record Regarding Other Acts Evidence Testified to by Dr. Morris for Purposes of Appellate Review

A separate record for appellate review was made to preserve certain testimony of Dr. Morris, which was excluded by the trial court. (3/21/15, 163-165) The testimony disallowed by the trial court would have informed the jury that Dr. Morris was familiar with other patient care rendered by Defendant in 8 to 10 other cases. Two to three of those cases involved nerve injuries during surgery (injuries to nerves in the neck and marginal mandibular nerve injury) and one involved a submandibular gland and tumor removal surgery. After review of the operative records in those cases, several commonalities emerge:

First, Defendant’s operative reports routinely do not characterize the problems concerning the surgeries he performs even when there is a significant complication. In other words, even in cases where there are significant complications, he frequently leaves out critical information. (3/23/15, 164)

Second, Defendant does not record his patients’ complaints, even where other doctors at MMENT who also saw the patients recorded complaints that necessarily had to be present when the patients saw Defendant. (3/23/15, 164)

Third, Defendant’s dissection abilities during surgery are seriously called into question where there have been a number of gross errors caused by inattention to details during the

surgical procedure. For example, he operated on one part of a patient's nose, which resulted in a problem on the other side of that patient's nose. He also performed surgery on another patient's nose, which resulted in that patient's blindness. On another occasion, he removed the wrong side of a patient's thyroid gland. (3/23/15, 165)

O. The Trial Court Rulings Pertinent to the Argument in Defendant's Application for Leave Regarding the Res Ipsa Loquitur Jury Instruction

During trial the Plaintiff presented expert testimony that the injury Plaintiff suffered to her right HGN was not the type of injury that would ordinarily occur absent negligence. (3/23/15, 87, 128-129, 136-137, 150-152, 154, 161) Defendant had objected to the testimony, but the trial court ruled based on *Niemi v Upper Peninsula Orthopedic Assoc, Ltd*, 173 Mich App 326; 433 NW2d 363 (1988), *Jones v Poretta*, 428 Mich 132; 450 NW2d 863 (1987), and *Woodard v Custer*, 473 Mich 1; 702 NW2d 522 (2005), that if there were expert testimony that if the injury suffered were not the result of an unfortunate complication of a reasonably performed medical procedure, but ordinarily does not occur absent negligence, the instruction would be given. (3/23/15, 84-85) Plaintiff presented the needed expert testimony and at the close of proofs, the trial court instructed the jury on the doctrine of res ipsa loquitur by giving the standard jury instruction 30.05. (3/27/15, 10) It refused to grant Defendant's request to also instruct on medical uncertainties with standard jury instruction 30.04, based upon the ruling in *Jones*, 428 Mich 132. (3/26/15, 56)

P. The Jury Verdict and the Appeal

The jury was instructed and deliberated for about four hours on March 27, 2015, before returning a verdict of no cause of action in favor of Defendant. (3/27/15, 24-25) Plaintiff filed a timely appeal raising numerous claims of error, including the improper exclusion of other acts

evidence. Defendant cross appealed raising two issues, one of which involved the trial court's jury instruction on the doctrine of res ipsa loquitur.

Q. The Court of Appeals Majority

On appeal Plaintiff argued, inter alia, that the trial court abused its discretion when it precluded the other acts evidence of Defendant's other surgeries, in which he failed to document his patients' post-operative complaints, which related to serious surgical errors. The Majority found this evidence relevant and not substantially outweighed by undue prejudice to Defendant. The Majority cited *Lewis v LeGrow*, 258 Mich App 175, 207; 670 NW2d 675 (2003), in which the Court of Appeals provided a concise formulation of the elements that must be satisfied for other acts evidence to be admitted and properly applied that formulation to the facts of the case at bar. The Majority acknowledged that pursuant to MRE 608(b), evidence from records of past medical malpractice cases is inadmissible to attack admissibility, that same evidence may be admissible under MRE 404(b), if it is offered for a non-character purpose. Thus, the other acts evidence at issue, which was being offered for a non-character purpose, was admissible.

The Majority addressed the third step regarding other acts evidence which is to determine if the probative value of the evidence is nevertheless substantially outweighed by unfair prejudice. It expressly found that the other acts evidence had substantial probative value and implicitly found it would not tend to cause a jury to give the evidence undue or preemptive weight. The Majority ruled that the trial court's decision to exclude the other acts evidence was an abuse of discretion, *Waknin v Chamberlain*, 467 Mich 329, 332; 653 NW2d 176 (2002), and the error affected Plaintiff's substantial rights. Reversal was therefore necessary. MCR 2.613. See also *Guerrero v Smith*, 280 Mich App 647, 655–656; 761 NW2d 723 (2008). *Ilins v Burns*, 388 Mich 504, 510-511; 201 NW2d 624 (1972); *Swartz v Dow Chemical Co*, 414 Mich 433; 326

NW2d 804 (1982). The Majority implicitly found that Plaintiff met her burden to show that the trial court's error was prejudicial and that the failure to reverse would be inconsistent with substantial justice. *Henson v Veterans Cab Co*, 384 Mich 486, 494; 185 NW2d 383 (1971).

On cross-appeal the Majority addressed Defendant's issue regarding the trial court instructing the jury on the doctrine of *res ipsa loquitur*. It found that the trial court did not abuse its discretion by giving the instruction because all of the conditions required to avail one of the jury instruction were met by Plaintiff. Dr. Morris stated his opinion that Plaintiff's injury is an event that normally would not have happened absent Defendant's negligence where, under the particular circumstances of Plaintiff's surgery, there is no reasonable explanation for her injury but Defendant's negligence. *Locke v Pachtman*, 446 Mich 216, 231; 521 NW2d 786 (1994). Plaintiff presented evidence that the harmonic scalpel was in the exclusive control of Defendant, that she did not actively and voluntarily contribute to her injury and that the true explanation of her injury is more readily accessible to Defendant than to her. Because the Majority found that the trial court's decision to instruct on *res ipsa loquitur* was supported by the facts of the case and by published authority, and thus not an abuse of discretion.

ARGUMENT

- I. THE COURT OF APPEALS MAJORITY CORRECTLY HELD THAT THE TRIAL COURT ABUSED ITS DISCRETION WHEN IT PRECLUDED RELEVANT OTHER ACTS EVIDENCE WHICH SUPPORTED PLAINTIFF'S ARGUMENT THAT DEFENDANT FAILED TO RECORD HER POST-OPERATIVE COMPLAINTS TO SHIELD HIMSELF FROM LIABILITY FOR NEGLIGENTLY INJURING PLAINTIFF'S RIGHT HYPOGLOSSAL NERVE DURING BENIGN SUBMANDIBULAR GLAND EXCISION SURGERY AND WAS NECESSARY FOR THE JURY'S PROPER EVALUATION OF THE FACTS REGARDING PLAINTIFF'S SURGERY AND POST-OPERATIVE COURSE OF TREATMENT.**

Standard of Review

The decision whether to admit evidence is within the trial court's discretion. *People v Starr*, 457 Mich 490, 494; 577 NW2d 673 (1998). If the admissibility of evidence involves a preliminary question of law, e.g., whether a rule of evidence or statute precludes admissibility of the evidence, it is reviewed de novo. *People v Lukity*, 460 Mich 484, 488; 596 NW2d 607 (1999).

Discussion

The trial court abused its discretion and erred when it denied Plaintiff the opportunity to present relevant other acts evidence regarding Defendant's record keeping in cases involving serious complications following his surgery. The trial court's error was prejudicial to Plaintiff because she was unable to present evidence that not only supported her testimony but supported her trial theory.

Although there was no evidence to support his contention and none of Defendant's experts could offer a mechanism of injury to Plaintiff's right HGN, Defendant suggested that post-operative scarring caused Plaintiff's nerve injury during opening statement.³⁵ Plaintiff

³⁵ This is the same response Defendant has made in every case where a patient has had a nerve injury after he has operated on them.

wanted to ask Defendant in front of the jury if he is aware of other incidents where he had patients with nerve injury following surgery, which he attributed to post-operative scarring. The trial court stated if Defendant were to get into his beliefs about the cause of the injury during his testimony, Plaintiff would be able to get into the other cases. (3/17/15, 146-150) Defendant was then careful to testify that he did not really know if post-operative scarring caused the problem.

Unfortunately, all the jury was presented with was Defendant's self-serving testimony bolstered by his credentials, training, experience in performing hundreds of these "routine" surgeries and the fact that he was the only witness to what he did during the procedure. Defendant's counsel later touted Defendant's decades of experience and hundreds of these surgeries under his belt "using the harmonic scalpel identifying the anatomy" during a hypothetical he posed during his cross-examination of Dr. Morris. (3/23/15, 117)

Naturally, none of the qualified experts could testify from first hand knowledge what exactly was done during Plaintiff's operation and during Plaintiff's post-operative course.³⁶ They had to rely on Defendant's records, which were inadequate at best and intentionally misleading at worst, and Defendant's testimony about what he did and how he did it. Given the posturing of Defendant as a highly experienced surgeon who was the only person who knew exactly what happened during the surgery as was pointed out by his counsel again and again, it was fundamentally unfair for the trial court to deprive Plaintiff of the opportunity to show the jury that Defendant had a system of failing to make a detailed surgical record and failing to record his surgical patients' post-operative complaints. This would support Plaintiff's testimony that she

³⁶ Defendant highlighted the fact that Dr. Morris was not in the operating room at the time of Plaintiff's surgery and so he could not know what Defendant did or did not do, again suggesting to the jury that they should believe what Defendant said happened during the surgery because only he really knew. 3/23/15, 129.

repeatedly told Defendant about the problems she was experiencing post-surgery, which would point to a nerve problem, even though none of her post-surgical complaints appeared in Defendants records.

Pursuant to MRE 402, all relevant evidence is admissible unless excluded under the Constitution, rules of evidence, or rules by the Michigan Supreme Court. Relevant evidence is evidence that has *any* tendency to make the existence of a fact at issue more probable or less probable than it would be without the evidence. The evidence sought to be introduced by Plaintiff was relevant. Relevant evidence is not limited to only evidence necessary to establish the elements of a cause of action. Rather, Michigan law has long recognized the credibility of a witness (defined as that quality in a witness which renders his evidence worthy of belief³⁷) is always relevant and may be attacked on cross-examination.³⁸

A. Other Patient Care and Negligently Performed Surgeries

The trial court abused its discretion when it prohibited Plaintiff from presenting the evidence of Dr. Morris, which was made part of a special record for purposes of this appeal. Dr. Morris would have informed the jury about his opinion after reviewing other patient care rendered by Defendant in 8 to 10 other cases, two or three involving nerve injuries during surgery and one involving a submandibular gland and tumor removal. After review of the operative records in those cases Dr. Morris noted several commonalities highly relevant to the issues in this case.

First, Defendant's operative reports routinely do not characterize the problems concerning the surgeries he performs even when there is a significant complication. In other words, even in

³⁷ *Black's Law Dictionary* (6th ed), p 366.

³⁸ *Lewis*, 258 Mich App at 211; MRE 611(c); *Lukity*, 460 Mich 484.

cases where there are significant complications, he frequently leaves out critical information. Even Defendant's own expert found Defendant's surgical note about Plaintiff's surgery limited and wanted more information to be able to tell about Plaintiff's surgery.

Second, from Dr. Morris's review he also noted Defendant does not record his patients' complaints, even where other doctors at MMENT who also saw the patients recorded complaints that necessarily had to be present when the patients saw Defendant. Plaintiff testified that she told Defendant about her complaints at every post-operative visit, yet none of her complaints about her tongue were ever recorded. Defendant testified he may have failed to record Plaintiff's complaints but it was "unlikely" and he was unaware of any situations where patients made complaints that he failed to record. Even Defendant's experts found Defendant's post-operative records to be inadequate.

Third, Defendant's dissection abilities during surgery have been seriously called into question where there have been a number of gross errors caused by inattention to details during the surgical procedure. There were several examples of this where Defendant's surgeries resulted in serious nerve injuries to the patient. At trial, Defendant described Plaintiff's surgery as a meticulously performed surgery, which took him 23 minutes to perform. Defendant's experts take more than three times longer to perform the same surgery, and described that these surgeries can be complicated. Plaintiff's experts pointed to Defendant's 23 minute surgery using the harmonic scalpel as the cause of Plaintiff's right HGN injury based on the record evidence.

The Majority correctly held that the trial court's refusal to allow the presentation of this evidence was an abuse of discretion and constitutes prejudicial error. Plaintiff maintained that Defendant intentionally created an inadequate surgical note and systematically omitted Plaintiff's post-surgical complaints suggestive of nerve injury in order to insulate himself from liability.

Plaintiff should have been allowed to present other acts evidence regarding identical issues in these other cases.

B. Evidence of Other Acts Pursuant to MRE 404(b)

The relevant other acts evidence supports Plaintiff's position that Defendant was not being truthful when he said it was unlikely that Plaintiff ever told him about the many difficulties she was experiencing post-operatively. The evidence was offered for a proper purpose: to show Defendant's plan, scheme and system of doing an act for the purpose (motive) of shielding him from liability. The trial court was concerned about prejudice to Defendant were the jury to learn about other malpractice cases against Defendant.³⁹ However, in light of the trial court's pretrial ruling precluding mention of other malpractice cases, Plaintiff informed the court that she would not mention the actual malpractice cases. She would bring in relevant other acts evidence which happened to be learned about from the numerous other cases against Defendant, which tended to support Plaintiff's claim that Defendant did not record the many, many times she told him about the issues she was experiencing with her tongue since the surgery. 3/19/15, 41.

A central issue at trial was when did Plaintiff begin experiencing her difficulties with her tongue, which would indicate when the right HGN injury occurred. Defendant did not record her complaints about her tongue difficulties, which affected her speech and ability to control her saliva and which she told him from the time of her first post-operative appointment and at every post-operative visit thereafter. Defendant testified it was unlikely she told him of her complaints because he did not record them. Plaintiff wanted to produce other acts evidence to support the fact that Defendant intentionally failed to record her problems. The evidence was in the nature

³⁹ Defense counsel cited *Wlosinski*, 269 Mich App 303 and argued the evidence of other lawsuits would be improper MRE 404(b) evidence. 3/19/15, 21-22.

claims by other patients that Defendant failed to record their complaints about problems experienced after Defendant performed surgery on them.

Under MRE 404(b), other acts evidence is “not admissible to prove the *character* of a person in order to show action in conformity therewith” but *may* be admissible for other purposes, such as proof of motive, opportunity, intent, preparation, scheme, plan, or system in doing an act, knowledge, identity, or absence of mistake or accident when the same is material. MRE 404(b)(1). Defendant testified he was not “specifically aware” of other situations where patients complained or made it known that they did not think he was writing down their post-operative complaints. This was a patently false statement as at the time he testified, Defendant had already been sued numerous times by patients who consistently claimed that he failed to chart their post-operative complaints, enabling him to claim that nothing could be linked to his surgeries. Dr. Morris also noted Defendant’s system in doing an act when he reviewed 8 to 10 of Defendant’s cases. This was Defendant’s *modus operandi* and the jury was deprived of this information which would have enabled them to root out the truth in this case.

When Plaintiff asked this follow-up question:

Q. How about specifically have you ever had patients make it known to you that they were having symptoms of, you know, nerve problems or irregularity after surgeries you performed that were not charted? [3/17/15, 138]

Defendant objected on the grounds of relevance arguing that the question was not probative to any issue relative to the claims in this case regarding whether the surgery was done in accordance with the standard of care. However, the timing of Plaintiff’s problems was critical to Defendant’s experts’ opinions that Plaintiff’s injury did not result from the surgery.⁴⁰ The trial court was

⁴⁰ Defendant also argued that because Defendant stated that it was “possible” Plaintiff made her issues known to him, that he just did not remember because no record reflected that she told him, Plaintiff could not impeach him with other acts evidence. 3/17/15, 140

concerned about having to “try cases within cases” but the issue was Defendant’s credibility and whether the jury should believe it was “unlikely” that Plaintiff told him of her complaints after surgery. The fact that there were other patients that Defendant was aware of who had stated that their complaints to Defendant after surgical procedures were not memorialized by Defendant in their medical records, supports Plaintiff’s testimony regarding her experience.

Defendant testified he was not “specifically aware” of other patients claiming that he failed to document their post-operative complaints, when in fact Defendant absolutely was aware that other patients made this exact complaint. Plaintiff voiced her concern that Defendant was not testifying truthfully, but she was not permitted to let the jury know this. (3/17/15, 143-144) The trial court’s erroneous ruling prevented Plaintiff from presenting proper other acts evidence to support a central issue at trial. The trial court abused her discretion regarding the admission of this relevant evidence. Its error was offensive to the maintenance of a sound judicial process and was not harmless.

Dr. Almeida an expert in neurology, determined after examination of Plaintiff’s tongue that the condition of Plaintiff’s tongue showed the problem *had been going on for a few years*. All of the experts in neurology explained how injury to a HGN would result in a progression of symptoms and that Plaintiff’s symptoms. What Plaintiff described and what Dr. Almeida saw upon examination, had been progressing since the surgery on August 3, 2010. Only Plaintiff’s neurology experts had direct experience with HGN injury. The otolaryngologists who testified as experts in the case did not possess the same level of knowledge or experience with HGN injury. They testified that HGN injury would be a rare injury to occur during benign submandibular gland excision surgery. None of them had ever actually seen such a nerve injury. Central to Defendant’s experts’ opinions that Defendant’s surgery could not have caused the right HGN

injury was the timing of the problems Plaintiff experienced. They believed Defendant's testimony and admittedly inadequate records which indicated Plaintiff did not have immediate problems with her tongue and mouth following Defendant's surgery.

C. The Probative Value of the Evidence Kept Out by the Court Substantially Outweighs the Danger of Unfair Prejudice

The probative value of the other acts evidence outweighed any prejudice to Defendant. MRE 403. Because Defendant could not recall the surgery or Plaintiff's post-surgical course, Defendant's experts relied in large part on Defendant's surgical note and post-operative records to determine whether Plaintiff's HGN injury occurred during the surgery. Their opinion was based on Defendant's records and the timing of the development of gross changes in Plaintiff's tongue. Defendant's records were devoid of any of Plaintiff's complaints which she testified she repeatedly told Defendant during her post-operative appointments. The other acts evidence supported Plaintiff's testimony and was probative of Defendant's claim that it was likely that Plaintiff never told him of her complaints or, if she did, he only inadvertently failed to record them. The other acts evidence was also probative of his motive to not record Plaintiff's complaints. A reasonable juror could conclude that Defendant did not record Plaintiff's post-operative complaints because he wanted to avoid a surgical complication being linked back to his surgery. Thus, other acts evidence was relevant to show motive and to help the jury weigh Defendant's and Plaintiff's credibility on this issue.

In *Waknin*, 467 Mich 329, the Court of Appeals reversing the trial court held that all evidence offered by parties is prejudicial to some extent, but the fear of prejudice does not generally render the evidence inadmissible. To be excluded, the probative value must *substantially* outweigh the danger of unfair prejudice. In the present matter, fairness and justice demands that the evidence be allowed to prevent a gross miscarriage of justice. In *People v*

Crawford, 458 Mich 376, 398; 582 NW2d 785 (1998), the Court stated MRE 403 does not prohibit prejudicial evidence, only evidence that is unfairly so. Evidence is unfairly prejudicial when there exists a danger that *marginally* probative evidence will be given undue or preemptive weight by the jury. The fundamental goal of MRE 403 is accuracy and fairness. *People v Vasher*, 449 Mich 494, 501; 537 NW2d 168 (1995). In *Wischmeyer v Schanz*, 449 Mich 469, 479; 536 NW2d 760 (1995), the Court stated, “It is intended that the Rules of Evidence promote the ascertainment of the truth. Where information is relevant and not unduly prejudicial, it would be unwise to apply MRE 608 so that the jury is deprived of information that would assist it in its task.” There is no reason the same could not be said with equal force regarding the application of MRE 404(b) and MRE 403. The evidence precluded by the trial court in this case was highly probative of Plaintiff’s contention that Defendant utilized a system of failing to record her complications traceable to Plaintiff’s right submandibular gland excision surgery in order to insulate himself from liability, and supported Plaintiff’s own testimony.

The Dissent’s disagreement with the Majority appears to be focused on the fact, that in some of the cases Dr. Morris reviewed, the harm to patients as a result of errors allegedly attributed to Defendant’s surgery would be too prejudicial to Defendant. But, as recognized by the Majority, any prejudicial effect could be addressed at the retrial and cured, or substantially ameliorated, by a limiting instruction given during and/or after the proofs. “[J]uries are presumed to understand and follow their instructions,” *Lenawee Co v Wagley*; 301 Mich App 134, 159; 836 NW2d 193 (2013), and limiting instructions are “generally sufficient to cure the prejudice arising from improper remarks of counsel . . .” *Tobin v Providence Hosp*, 244 Mich App 626, 641; 624 NW2d 548 (2001).

D. The Omission of Relevant Evidence Was Not Harmless

Harmless-error analysis governs evidentiary rulings and decisions by the trial court. See MCR 2.613(A). By refusing to allow Plaintiff's expert to present other acts evidence demonstrating Defendant's pattern of failing to record patient complaints in cases of where there were serious complications, and Defendant's motivation for that pattern, Defendant was permitted to suggest that Plaintiff did not have problems worth noting and her HGN injury could not possibly be connected to his surgery. The trial court's error was not harmless. Defendant's record of Plaintiff's treatment is silent regarding all of Plaintiff's post-operative complaints including her tongue biting and drooling she experienced immediately after surgery. As recognized by the Majority: "If such silence is due to the systematic omission of complications traceable to surgery, then excluding the other acts evidence was not harmless." *Merchand v Carpenter*, unpublished opinion per curiam of the Court of Appeals, issued Aug. 2, 2016 (Docket No. 327272), p 6; 2016 WL 4129225. The other acts evidence excluded by the trial court supported Plaintiff's theory that her HGN was injured during surgery. In this regard the other acts evidence is of significant probative value to the jury charged with fairly and accurately determining whether Defendant omitted Plaintiff's complaints because she never told him of her complaints or they were inconsequential and did not merit recording because they were normal parts of the healing process, or, as Plaintiff contends, because they were the type of complications from surgery that Defendant systematically excludes from patients' records to shield himself from liability. It was for this reason that the Majority correctly concluded that substantial justice required vacating the jury's verdict and remanding the matter to the trial court for a new trial. Leave to appeal should be denied.

II. THE COURT OF APPEALS MAJORITY DECISION WAS NOT CLEARLY ERRONEOUS WHEN IT CORRECTLY HELD THAT THE TRIAL COURT DID NOT ERR IN GIVING THE STANDARD JURY INSTRUCTION, M CIV JI 30.05 [RES IPSA LOQUITUR] AND NOT THE JURY INSTRUCTION ON MEDICAL UNCERTAINTIES [M CIV JI 30.04] WHERE PLAINTIFF PRESENTED EVIDENCE TO SUPPORT THE DOCTRINE OF RES IPSA LOQUITUR

Standard of Review

Claims of instructional error are reviewed de novo. *Jones*, 428 Mich at 154, n 8; *Taylor v Kent Radiology*, 286 Mich App 490, 500; 780 NW2d 900 (2009). “[W]hen requested by a party, a standard jury instruction must be given if it is applicable and accurately states the law.” *Jackson v Nelson*, 252 Mich App 643, 647; 654 NW2d 604 (2002). The determination whether an instruction is accurate and applicable based on the characteristics of a case is within the sound discretion of the trial court. *Stevens v Veenstra*, 226 Mich App 441, 443; 573 NW2d 341 (1997).

Discussion

In a medical malpractice case, the plaintiff has the burden of proving: “(1) the applicable standard of care, (2) breach of that standard by defendant, (3) injury, and (4) proximate causation between the alleged breach and the injury.” *Cox v Flint Bd of Hosp Mgrs*, 467 Mich 1, 10; 651 NW2d 356 (2002). Here, it is undisputed that Plaintiff suffered an injury to her right HGN. The only question at trial was whether or not the injury occurred at the hands of Defendant during his surgery on Plaintiff to remove her benign right submandibular gland. At trial Plaintiff presented expert testimony on the remaining necessary elements: the applicable standard of care for submandibular gland excision surgery, Defendant’s breach of that standard when he performed the surgery on Plaintiff, and that Defendant’s breach of the standard of care was the proximate cause of the injury to Plaintiff’s right HGN. Contrary to this evidence, Defendant maintained he did not breach the standard of care and that Plaintiff’s injury was just one of those things that can happen during a submandibular gland excision surgery. Defendant claimed that damage to the

HGN (which results in a deformed tongue) was a known and accepted risk of this particular surgery and therefore the injury was not caused by his negligent performance of the surgery.

Expert testimony is the traditional method of proving medical malpractice and even in cases involving the doctrine of *res ipsa loquitur*, which is a recognized exception to the need for expert testimony, a plaintiff must still utilize expert testimony if the issue is one outside of the purview of a lay person. *Locke*, 446 Mich at 230. Plaintiff utilized expert testimony in this case because the issue presented was clearly outside the purview of a lay person. Medical malpractice cases in Michigan also require that the plaintiff prove the breach of the standard of care, or “more than a bad result.” This is accomplished with expert testimony that the injury complained of would not have happened had the plaintiff been treated in accordance with the appropriate standard of care. *Jones*, 428 Mich at 151-156. *Res ipsa loquitur* is a doctrine that permits a plaintiff to establish a *prima facie* case of negligence with circumstantial evidence. *Id.* at 150. It is not a theory of negligence, which must be pleaded. “The major purpose of the doctrine of *res ipsa loquitur* is to create at least an inference of negligence when the plaintiff is unable to prove the actual occurrence of a negligent act.” *Id.*

It is not disputed that Plaintiff’s tongue was healthy and in good working order when she went in for surgery. After surgery Plaintiff began experiencing difficulties, including excessive spitting and biting her tongue. Plaintiff’s expert reviewed the documentary evidence and opined that Plaintiff’s injury must have occurred during surgery and that the type of injury Plaintiff sustained could not be explained by any other mechanism. All other possible causes, including infection on the basis of the post-operative notes, were ruled out. The only logical inference to be made is that Defendant’s surgical procedure was the proximate cause of Plaintiff’s injury to her

right HGN. Plaintiff presented evidence sufficient for application of the res ipsa loquitur doctrine.

Defendant first argues that the doctrine does not apply in this case because Plaintiff did not establish the requirements of res ipsa loquitur during trial. Defendant's Application for Leave to Appeal, Argument D(1) at 40-45. Defendant then argues that the trial court erred in instructing on res ipsa loquitur because res ipsa loquitur must be specifically pleaded in the complaint and affidavit of Merit. Defendant's Application for Leave to Appeal, Argument D(2) at 45-49. Defendant is wrong on both points.

A. Plaintiff presented sufficient evidence on each res ipsa loquitur factor.

To get the jury instruction on the doctrine of res ipsa loquitur, Plaintiff had to show: 1) that the event was of a kind which ordinarily does not occur in the absence of negligence; 2) that it was caused by an agency or instrumentality within the exclusive control of the defendant; 3) that it was not due to any voluntary action of the plaintiff; and 4) that evidence of the true explanation of the event was more readily accessible to the defendant than to the plaintiff. *Woodard*, 473 Mich at 7, citing *Jones*, 428 Mich at 150-151. Plaintiff presented evidence on each factor. Defendant only argued on cross-appeal to the Court of Appeals that Plaintiff did not present evidence on the first factor.

1. The injury to Plaintiff's right HGN was of a kind which *ordinarily* does not occur in the absence of negligence.

With regard to the first factor, the Michigan Supreme Court has held that "the fact that the injury complained of does not ordinarily occur in the absence of negligence must either be supported by expert testimony or must be within the common understanding of the jury." *Locke*, 446 Mich at 231. Whether injury to a hypoglossal nerve during benign submandibular surgery ordinarily occurs in the absence of surgical negligence is not within the common understanding of the jury, and expert testimony was required and presented by Plaintiff. Plaintiff's expert, Dr.

Morris specifically testified that injury to the HGN during benign submandibular gland excision surgery is very rare. It is not an injury that would *ordinarily* occur absent negligence. (3/23/15, 42-45, 48, 52, 65-69, 71, 87, 125-126, 129, 137, 150-151, 160-161) Ordinarily it is recognized as a risk only in *negligently* performed benign submandibular gland excision surgery. There is no question that Plaintiff's right submandibular HGN was normal before the surgery and Plaintiff had symptoms consistent with damage to the HGN after surgery which progressed during Plaintiff's post operative course and after until her tongue became deformed. While Dr. Morris acknowledged that there can be inflammation with infection after surgery that could temporarily or permanently affect nerve function (145), he maintained that the injury sustained by Plaintiff could only have occurred as a result of negligence, in light of the medical records. (3/23/15, 86-87, 151-152, 154, 161)

There was testimony that if a surgeon encounters difficulties or the patient's anatomy is atypical, the HGN may be at risk of injury, but the evidence presented by Defendant showed there were no complications or difficulties during the surgery and Plaintiff's anatomy was typical. Defendant criticizes Dr. Morris because he could not reliably state that 100% of the time, "without exception," when an injury occurs to the HGN during benign submandibular gland excision surgery it must be a result of the negligence. See Defendant's Application for Leave to Appeal at 44. He stresses that the first factor of *res ipsa loquitur* requires the event be "of a kind" which ordinarily does not occur in the absence of negligence. Plaintiff presented expert testimony that the event, or injury to Plaintiff's right HGN occurred when it was transected by Defendant during surgery. This certainly was an event which *ordinarily* does not occur in the absence of negligence. The use of the word "ordinarily" denotes that the injury does not have to be one which "... 100% of the time, 'without exception, ...'" only occurs as a result of negligence.

Plaintiff's position at trial was that the injury Plaintiff suffered was not a known risk and complication of a properly performed surgery. This was why consent was not an issue.⁴¹ Because the injury to Plaintiff's right HGN was not a recognized risk and complication of *properly* performed benign submandibular gland excision surgery, in the absence of any other explanation for the injury, her injury was the result of Defendant's negligence in performing the surgery.

Defendant made the bald assertion that the injury to Plaintiff's right HGN is a known risk and complication of the surgery.⁴² But there must be a difference between an accepted complication and a complication as a result of a doctor's negligence and substandard care. Defendant states that "[n]erve injuries during surgery are oftentimes considered inherent risks and complications of the procedure" and cites to surgeries different from the surgery performed by Defendant on Plaintiff. Defendant's Application for Leave to Appeal at 42. But Defendant said injury to the HGN during benign submandibular gland excision surgery was very, very rare,

⁴¹ Defendant relied on the standard pre-printed consent form for "excision of lymph node, cyst or neck mass" to support his claim that Plaintiff's injury was a known risk of the procedure. The form indicates that there is a risk of damage to "any one of these nerves" without any mention of what "these" nerves would be. The form also states someone "will advise you of specific risks in your case" but Defendant testified he would only go into specific risks if the patient specifically asked him to do so. (3/17/15, 102-105)

⁴² Defendant points to Dr. Rontal and Dr. Borovic's testimony to argue HGN injury can occur in the absence of negligence during benign submandibular gland excision surgery. What Dr. Rontal actually said was the HGN can be injured in the absence of negligence because doctors are "not robots" and they "can't always see everything [they] do." (3/24/15, 146-147) Dr. Borovic offered the observation that in a gland that is chronically infected, it is very difficult to see where the surgical planes are because they are "kind of melded together so the surgery can be complicated." (3/24/15, 28) But, Defendant was quite specific that there were no complications and he encountered no difficulties in performing his 23 minute surgery. Neither Dr. Borovic (3/24/15, 107) nor Dr. Rontal (3/24/15, 197) had ever seen a case where the HGN was injured during this procedure and neither could identify any mechanism of injury to Plaintiff's right HGN.

and neither he, nor his experts were aware of any other patient sustaining a permanent injury to the HGN from benign submandibular gland excision surgery.

Defendant also criticizes Dr. Morris for not accounting for “the fact of infection” he says occurred eight days post-surgery. Defendant’s Application for Leave to Appeal at 43. But there was no evidence that Plaintiff developed a severe post-operative infection that would cause permanent injury to Plaintiff’s right HGN. Defendant could not offer any mechanism of how injury to Plaintiff’s right HGN occurred, but he did suggest the HGN could become injured in the absence of negligence in a case where there was scarring following a *severe* post-operative infection. Since this did not occur in Plaintiff’s case his suggestion is irrelevant to the determination of whether Plaintiff presented evidence that the injury suffered by Plaintiff was of a kind which ordinarily does not occur in the absence of negligence.

Defendant’s experts acknowledged Plaintiff did not have a severe infection. Plaintiff’s experts noted that even if there were a post-operative infection, it was successfully treated with antibiotics and it was not of a kind that would result in permanent injury to the HGN. Plaintiff is compelled to point out that inflammation is not the same as infection. Plaintiff suffered from chronic inflammation of the submandibular gland. In the absence of any other plausible explanation the injury occurred as a result of Defendant’s negligent surgery.

Inexplicably, Defendant argues that there was “discreet testimony” that injury to Plaintiff’s HGN did not occur “at all” because if it had occurred, there would have been immediate symptomology. This argument was specifically countered in Plaintiff’s Brief on Appeal, pp 28-34. Dr. Schechter had experience with patients who had injuries to the HGN. He noted Plaintiff had a *progression* of symptoms which led to the tongue deviating due to atrophy and Plaintiff remains symptomatic. (3/20/15, 19-20, 27, 70-71) Dr. Schechter’s opinion to a

degree of medical certainty is that Plaintiff's HGN was injured during surgery by something Defendant did. Dr. Almeida, an expert neurologist examined Plaintiff in early April 2013, and found the problem with Plaintiff's tongue was chronic and had been going on for a few years and progressed to include tongue atrophy, weakness and fasciculations. In her expert opinion Plaintiff suffered an HGN injury during the August 3, 2010 surgery. Both Defendant and his two experts said injury to the HGN would result in an obvious immediate cessation of motor function. These doctors were not experts in the diagnosis and treatment or management of nerve injuries and neurological diseases. Neither Drs. Borovik nor Rontal had ever had a patient who sustained an HGN injury. Even Defendant was unaware of anyone suffering an injury to the HGN as a result of benign submandibular gland excision surgery. Plaintiff presented sufficient evidence that the injury to her right HGN was of a kind which ordinarily does not occur in the absence of negligence, and therefore satisfied the first factor of the doctrine of *res ipsa loquitur*.

Defendant did not raise any issue regarding the remaining three factors needed in order to get the *res ipsa loquitur* jury instruction, and thus has conceded that Plaintiff presented sufficient evidence on those factors. Plaintiff was entitled to the instruction.

B. There is no requirement that *res ipsa loquitur* be specifically pleaded in a complaint before a jury can be instructed on the doctrine, because it is not a theory of liability.

Defendant objected to the testimony of Dr. Morris regarding the issue of whether the injury Plaintiff sustained during Defendant's surgery could occur in the absence of negligence because *res ipsa loquitur* was not specifically plead in the Complaint. He directed the trial court to *Via v Beaumont*, unpublished opinion per curiam of the Court of Appeals, issued Oct. 21, 2014 (Docket No. 316766); 2014 WL 5364119 (attached as Exhibit H to Defendant's Application for Leave to Appeal) to support his argument.

While the *Via* panel took the position that *res ipsa loquitur* must be specifically pleaded in the complaint, Plaintiff maintains this is not consistent with Michigan precedent. The doctrine of *res ipsa loquitur* is not a separate claim of liability, but a method proving a claim of negligence. See *Wischmyer*, 449 Mich at 483-484; *Jones*, 428 Mich at 150. See also *Locke*, 446 Mich at 230 and 57B Am Jur 2d, Negligence, § 1176, p 419 (stating that “[a]ccording to most authorities, the doctrine of *res ipsa loquitur* is merely an evidentiary or procedural rule, and not a rule of substantive law, and thus it does not create or constitute an independent or separate ground of liability”).

Plaintiff specifically addressed this point at trial in response to Defendant’s objection to Dr. Morris’s testimony. The trial court, relying on *Niemi*, 173 Mich App 326 (which cites to *Jones*, 428 Mich 132) and *Woodard*, 473 Mich 1, ruled that Plaintiff was entitled to ask her expert witnesses if the injury Plaintiff sustained is one that would ordinarily occur absent negligence. If the Plaintiff presented evidence on the remaining November 21, 2016 factors of *res ipsa loquitur*, she would be entitled to the jury instruction. The trial court’s ruling was correct and the Court of Appeals Majority did not err when it upheld the trial court’s ruling. If there is evidence that but for negligence this injury does not ordinarily occur, even if that evidence is disputed, the jury is to determine whether a plaintiff has proven whether it is more likely than not that the defendant’s negligence caused the plaintiff’s injury. *Jones*, 428 Mich at 154-55.

Plaintiff alleged in her Complaint that “but for” Defendant’s negligence in performing the surgery, the type of injury Plaintiff sustained to her right HGN would not have occurred. Plaintiff was required to, and did, present expert testimony by Dr. Morris to this effect. Although Defendant disputed the testimony of Dr. Morris, the jury, if it had believed Dr. Morris, could have found that “but for” Defendant’s negligence in performing the surgery, the injury to

Plaintiff's right HGN would not ordinarily have occurred. Because Plaintiff presented evidence on all four factors of res ipsa loquitur, Plaintiff was entitled to have the circumstantial jury instruction. SJI2d 3.10; *Jones*, 428 Mich at 157.

Defendant relies also on the unpublished case *Dube v St John Hosp & Med Ctr*, unpublished opinion per curiam of the Court of Appeals, issued May 16, 2006 (Docket No. 265887); 2006 WL 1329156 (attached as Exhibit P to Defendant's Application for Leave to Appeal) to support his contention that the res ipsa doctrine must be specifically plead in the Complaint to avail oneself of the doctrine. But the *Dube* case does not advance Defendant's argument and is not even related to the issue before this Court.

The trial court granted the defendant in *Dube* summary disposition pursuant to MCR 2.117(C)(7) on the basis that the affidavit of merit signed by the plaintiff's expert witness did not comply with MCL 600.2912d(1). Because the affidavit of merit did not comply with MCL 600.2912d, the statute of limitations was not tolled when the complaint was filed and plaintiff's claims were barred by the statute of limitations. The plaintiff tried to argue on appeal that an affidavit was not necessary in a res ipsa case so it did not matter that her affidavit of merit was deficient. This reasoning was rejected by the appellate court because all medical malpractice cases require an affidavit of merit. *Dube*, unpub op at 6. The *Dube* Court never stated directly or by implication that the affidavit of merit or a complaint must refer to res ipsa in order to entitle a plaintiff to the res ipsa loquitur instruction at trial when the plaintiff presents evidence on the four factors of the doctrine.

CONCLUSION

For the reasons stated above, this Court should deny Defendant's Application for Leave to Appeal. The Court of Appeals Majority correctly held that the trial court wrongly excluded

relevant and highly probative other acts evidence of Defendant's system of record keeping in cases in which there are serious complications to shield himself from liability for negligent surgery. The Majority correctly ruled that the trial court's ruling was prejudicial to Plaintiff and that fairness and accuracy demand the jury be presented with sufficient evidence to determine whether Defendant inadvertently failed to record Plaintiff's post-operative complaints or whether his failure to record was part of a scheme, plan or system to insulate himself from liability.

The doctrine of *res ipsa loquitur* is not a separate claim of liability but a method proving a claim of negligence. There was no need for Plaintiff to use the magic words "*res ipsa loquitur*" in her Complaint or allege facts on each factor to be established. Plaintiff alleged a number of facts regarding Defendant's surgery but for which Plaintiff would not have suffered an injury to her right HGN. Sufficient evidence was presented at trial, particularly the testimony of Drs. Morris and Schechter, to satisfy all four factors of the doctrine of *res ipsa loquitur*. The Court of Appeals' decision to uphold the trial court's ruling regarding the *res ipsa loquitur* jury instruction was not clearly erroneous. Given that this instruction is inconsistent with standard jury instruction 30.04 pursuant to *Jones*, 428 Mich 132, the Court of Appeals was not erroneous when it upheld the trial court's refusal to instruct the jury on medical uncertainties as requested by Defendant. The Court of Appeals Majority analyzed the issue correctly and applied the appropriate facts to the law. This Court should therefore deny Defendant's Application for Leave to Appeal.

Respectfully submitted,
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